1657

GIG NHS | Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

[redacted]

Eich Cyf Your ref: INQ1530C

Dyddiad/Date: 16th October 2013

PRIVATE AND CONFIDENTIAL
Louise Hunt
HM Coroner for Bridgend, Glamorgan & Powys
Rock Grounds
First Floor
Aberdare
CF44 7AE

Dear Mrs Hunt,

Re: Terence O'Connell Inquest (deceased) Schedule 5

I write in response to your letter of 28th August 2013, with regard to the above matter. The Health Board respectfully acknowledges and accepts the findings of the inquest held on 22nd August 2013.

The Health Board held a Post Inquest meeting to discuss the verdict and practical solutions to reduce future risk. Following the meeting the ABMU General Practitioner Out of Hours Service and the District Nursing Services have provided the attached action plan and reports.

The matters of concern relating to the Health Board were as follows:-

1. There was a communication breakdown between the care home, district nurses and out of hours GP on the 3rd may 2013, resulting in Mr O'Connell not being seen by any clinical staff.

The Health Board has implemented a clear and accurate message sheet, SBAR (Situation, Background, Assessment, Recommendation), for the switchboard staff at the Princess of Wales Hospital to record all out of hours requests for District Nurses in greater detail. The SBAR forms will ensure clear, audible records of referrals to the District Nursing Service in the Bridgend Locality, supporting safe, high quality patient care and the ability to review information and audit.

3. Mr O'Connell did not have any clinical assessment of his condition for 2 days until his admission to hospital.

[redacted] Clinical Manager for the GP OOH Service has discussed this case on two occasions with nurse management and agreed that in future all handover of care should be made person to person and not via messages left at switchboard.

The District Nurses in Swansea and Neath Port Talbot Locality currently provide the GP OOH Service with a weekend rota of the District Nurse's on duty mobile telephone numbers. It is planned that this system will to be introduced in October 2013, in Bridgend, once the new 24 hour shift pattern is introduced.

[redacted] has written to all the out of hours GP's to remind them that they must speak directly to the clinician who they wish to involve in the patient's care and ensure that responsibility has been passed to that person. It has been pointed out that this procedure must be followed at shift changing times and outstanding problems are communicated verbally and directly to the GP coming on shift.

I hope that the information provided satisfies the questions that you raised and demonstrates the changes implemented and evidences how seriously the Health Board has considered this matter.

Please do not hesitate to contact me further if my staff or I can be of any further assistance to you in this matter.

Yours sincerely

Paul Roberts

PAUL ROBERTS
CHIEF EXECUTIVE

Enc. GP OOH report, DN's report, DN's action plan.

GIG NHS
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

[redacted]

ABMU GP OOH Service
c/o The Grove Medical Centre
6 Uplands Terrace
Uplands
Swansea
SA2 0GU

23rd September 2013

PRIVATE & CONFIDENTIAL

Re Terence O'Connell - No 310476

The ABMU GP OOH Clinical Managers became aware of this case on 9th May 2013. The clinical notes were seen by all Clinical Managers and I listened to all recorded conversations on 10th May 2013.

1st Call indicated that patient complaining of lower abdominal pain and pain where catheter was inserted. Catheter was draining but not as much as usual. GP judged this to be a catheter drainage problem and contacted District Nurse

2nd call DN explained to the triage GP, [redacted] she had talked to the home already; she informed GP that she would not be able to flush the catheter as there were no DN notes or equipment there and suggested that the home monitor the fluid input and output. After a long discussion it was suggested by [redacted] that there may be a UTI with some sediment which might need a washout and that there may be notes available. [redacted] agreed to locate the notes and the nurse agreed to assess – actually said "yes we can sort something out that's fine" following [redacted] statement that "if you find any issues and he needs to go in for a flush let us know"

3rd Call [redacted] phoned Care Home & was informed that son was already bringing notes and equipment to the home.

4/5th Call DN informed [redacted] that equipment has been delivered to the care home but no notes and that she couldn't do anything even if she attended. Home visit agreed by [redacted]

6th call made by OOH GP in error to son-in-law – meant to talk to care home

7th Call [redacted] re-triaged call with staff. He suggested that the patient would have to go to A&E for catheter change. Carer suggested that she should phone the matron who may be trained in Catheter management

8th Call Matron declined to attend but son in law had just phoned the home to say that he had found the DN notes and was bringing the notes down. She had phoned the DN and was waiting for a reply. [redacted] said that if for any reason the DN could not visit he would be happy to do so.

9th Call [redacted] attempted to contact the DN via POW switchboard. There was split recording due to the patching of the call and I was unable to establish whether there was a direct person to person conversation.

10th Call [redacted] called the Care Home. He said he had left a message for the DN and he saw no reason for her not to call. He told [redacted] (the care worker who he had dealt with all along) that he was closing the call but if there was any problem she was to contact OOH again.

The Clinical Managers agreed that the advice given by both [redacted] was reasonable at the time and that [redacted] had "safety netted" the patient in his final call. However all agreed that there was a communication problem and that [redacted], as he had not been contacted by the DN on duty following the 8th call, should have checked with the DN or the Care home to ensure that the patient had been seen.

OOH had requested on several occasions the statement from this DN and asked for reasons why she had not made further contact with [redacted] after making the decision that she would not visit.

I have discussed this case on two occasions with nurse management and agreed that in future all handover of care should be made person to person and not via messages left at switchboard.

DNs in Swansea and NPT give OOH a rota of DNs on duty over the weekend with mobile contact numbers. It is hoped that this system will be extended to Bridgend when the new 24 hour shift pattern is introduced in October 2013. Between Monday and Fridays contact is made with DNs via the Hospital Switchboards in each of the three localities.

OOH had informed the DN Service in Bridgend that the most efficient way to contact OOH Drs was to use the contact telephone number for the Primary care Centre in Morriston Hospital [redacted] rather than using the Primecare call handling service as all such calls are logged as urgent by the OOH Reception staff and responded to as rapidly as possible by the OOH GPs.

I feel that there is a lack of understanding of the ABMU OOH Service, particularly in Bridgend and NPT. I have extended an invitation to the nurse managers in both areas to the OOH admin office to see the recording and clinical systems and to visit one of the OOH Centres to see the system in operation.

I have written to all GPs working for the OOH Service reminding them that they MUST speak directly to the clinician who they wish to involve in the patient's care and make it clear that responsibility has been passed to that person. I have pointed out that this procedure must be followed at shift changing times and any outstanding problems are communicated verbally and directly to the GP coming on shift.

[redacted]
Clinical Manager
ABMU GP OOH Service

Report Regarding The DN Care of MR TO'C by the out of hours district nursing service on 3rd May 2013

At 7.30pm on 03.05.13 staff nurse [redacted] received a phone call via her mobile to contact Monkstone House residential home. [redacted] contacted the home and was advised that TO'C was a respite patient with an indwelling urinary catheter insitu. TO'C was reported as having abdominal pain and penile burning not relieved by analgesia but was otherwise his usual self. [redacted] was informed the catheter was draining clear urine and seemed to be working fine. As the catheter was draining freely [redacted] assessed that the catheter was not blocked and the most likely cause was a urinary tract infection. The carer advised there weren't any district nursing notes available for Mr TO'C at the home. [redacted] then advised the carer she would speak to the out of hours GP service and she then spoke to the out of hours receptionist for the GP triage doctor to make contact with the care home to assess further.

At approx 19.50hrs [redacted] rang the care home and advised the carer that the GP would ring her shortly.

At approx 20:15hrs [redacted] received a phone call on her mobile from the GP [redacted] who requested [redacted] visit the care home and administer a washout or change the catheter. [redacted] advised she did not have any washouts as they are prescribed for individual patients and she did not feel it was the appropriate course of action as the catheter was draining freely and her assessment indicated an infection which required a medical review. [redacted] further advised that the reason there weren't any district nursing notes at the home to verify the need for the catheter as the DN service had not been alerted to Mr Oc's admission for respite [redacted] contacted [redacted] again and again requested that [redacted] visit and have a look at the catheter. [redacted] declined and stated she thought TO'C needed a GP visit to rule out an infection and a medical review of the cause of the abdominal pain. [redacted] advised she would attend after the GP visit if the GP deemed it necessary.

At 20:25hrs [redacted] again phoned [redacted] and asked if she would visit TO'C as the district nursing notes were now being taken to the home. [redacted] contacted the care home who again advised there we not any district nursing notes in the home and the catheter was draining freely. [redacted] rang [redacted] and requested a GP attend to assess the abdominal pain as the catheter was still patent and draining and the patient needed a medical assessment, the GP visit was agreed.

[redacted] span of duty finished at 21:00 hours however owing to the workload that evening she remained on duty later [redacted] contacted night staff nurse [redacted] at approx 21:15hrs to inform her of what had happened and that the GP was going to visit.

At approx 21:20hrs the carer from Monkstone rang [redacted] and stated the GP had referred TO'C back to the district nurses as it was a catheter problem, the carer further stated that the GP had informed her the district nurses were refusing to

attend. [redacted] informed the carer the district nurses were not refusing to but that from the information they were given this was nota catheter problem and that a medical assessment was required in order to find out the cause for his abdominal pain. [redacted] asked if the catheter was continuing to drain freely and she was informed the bag was now ¾ full. [redacted] was then satisfied that the catheter was draining freely.

As [redacted] was aware that [redacted] would be visiting patients at this point she contacted the switchboard herself despite being off duty at 21:35hrs and it was confirmed that they had received a call from the GP, had alerted [redacted] to this and were waiting for [redacted] to ring them back.

At approx 22:20hrs the Health Care Support Worker accompanying [redacted] observed the missed call on the mobile phone and rang switchboard to be informed that they didn't need to worry as the situation regarding TO'C had been sorted out we are unsure why this information was relayed to [redacted] at that time.

At approx 00:30hrs switchboard rang [redacted] asking her to ring Monkstone house. [redacted] then rang Monkstone House and the carer advised that nobody had visited and she had been told to expect a visit from the GP. The carer advised TO'C was still experiencing abdominal and penile pain and the catheter was draining 'fine'. [redacted] explained that it was probably an infection which required antibiotics, which would need to be prescribed by the GP. [redacted] asked if the carer wanted her to ring the GP for her but the carer said she was happy to do so herself. [redacted] repeated the conversation out loud to her Health Care Support Worker colleague, which is her general practice. The phone conversation ended with an agreement that the carer would contact the GP.

This was the last contact made to the district nursing service regarding TO'C.

Conclusion

The district nursing staff made an appropriate assessment on the information supplied by the care home i.e. that the catheter was draining freely, and therefore the cause of the pain would not have been a blocked catheter.

There was a dispute between the district nursing staff and out of hours GP's in relation to the fact that this gentleman required a medical not a nursing assessment at that point in time.

The communication between the Nurse and the GP was not clear in what was being requested and the reasons why.

Messages were passed between switchboard and clinicians which reduced the opportunity for clinical dialogue between the nurse and the GP which may have led to a different outcome.

There is a gap in information available as to why the nurse [redacted] was told by the switchboard that she did not need to attend to MR OC at 22.20, however the system for recording messages in Princess of Wales switchboard did not contain sufficient details to audit the messages or identify the person responding to this call.

ACTION PLAN

RE: TO'C

Date 07.10.13

ISSUE IDENTIFIED	ACTIONS	RESPONSIBLE PERSON	START DATE	REQUIRED OUTCOME/ OBJECTIVES	DATE OF COMPLETION	COMPLETED BY
Absence of clear and accurate records of messages passed on to district nursing staff by POW switchboard when working out of hours in the Bridgend Locality	Clear and accurate message sheets to be utilised in Princess of Wales switchboard	Bridgend Professional Lead for District Nursing	September 2013	Clear, auditable records of referrals to the district nursing service in the Bridgend Locality, supporting safe, high quality patient care and the ability to review information and audit	1st October 2013	Operational Team Leader
Need for clarity in communication with out of hours GP service	Use of SBAR's for clarity in referrals and recording of detail of referrals and agreed actions. Training required for the use of SBAR's	Bridgend Professional Lead for District Nursing	October 2013	Clarity in communication between district nursing service and out of hours GP service, supporting safe, high quality patient care	31st October 2013	

ACTION PLAN

RE: TO'C

Date 07.10.13

ISSUE IDENTIFIED	ACTIONS	RESPONSIBLE PERSON	START DATE	REQUIRED OUTCOME/ OBJECTIVES	DATE OF COMPLETION	COMPLETED BY
Importance of clinician to clinician discussion agreeing responsibility for any outstanding actions/ continuation of care	Use of SBAR's for clarity in referrals and recording of detail of referrals and agreed actions. Training required for the use of SBAR's and issue identified	Bridgend Professional Lead for District Nursing	October 2013	Clarity in communication between district nursing service and out of hours GP service, supporting safe, high quality patient care	31st October 2013	
Lack of process in place to escalate the issue re the dispute between the two clinicians	To develop a clear escalation process out of hours	Bridgend Professional Lead for District Nursing	October 2013	Clarity of when and who to escalate clinical issues to out of hours		